TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-3124-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 22, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Cyclobenzaprine HCl 10 MG is **medically necessary:** … to decrease muscle spasms … to allow activities of daily living…"

Amount in Dispute: $94.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "[This claim] is the Texas Star Network… Because this is network healthcare Rule 133.307 does not apply…

Texas Mutual denied medication Cyclobenzaprine HCL Tabs as there is no documentation submitted to support the initial use of the medication for this patient. Texas Mutual has not received any medical for this first billed medication and no current medical information was submitted with the billing."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2015	Prescription Medication (Cyclobenzaprine)	$94.50	$81.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.210 defines the documentation requirements for medical bills.
2. 28 Texas Administrative Code §133.305 defines the terms used for medical disputes.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.540 sets out the guidelines for use of the closed formulary for claims subject to certified networks.

5. 28 Texas Administrative Code §134.503 sets out the guidelines for billing and reimbursing prescription drug services.
6. Texas Insurance Code §1305.101 defines the duties of networks to provide medical treatment.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 854 – Documentation does not support the initial use of the medication for this patient.

Issues

1. Does the Division of Workers' Compensation (the Division) have jurisdiction to decide this dispute?
2. Is documentation required for the disputed services pursuant to 28 Texas Administrative Code §133.210?
3. Did the insurance carrier request additional documentation in accordance with 28 Texas Administrative Code §133.210?
4. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier states that the claim is in the Texas Star Network and indicates that the Division does not have jurisdiction to decide a medical fee dispute. Texas Insurance Code §1305.101 (c) states, "Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, **may not, directly or through a contract, be delivered through a workers' compensation health care network.** Prescription medication and services shall be reimbursed as provided by Section 408.0281, Labor Code, other provisions of the Texas Workers' Compensation Act, and applicable rules of the commissioner of workers' compensation" [emphasis added].

   Review of the submitted documentation indicates that this dispute is related to prescription medication. The Preamble of 28 Texas Administrative Code §134.540, effective January 17, 2011, 35 TexReg 11344, states that the rule "concerns the requirements for the use of the pharmacy closed formulary for claims subject to certified networks." In addition, "the Division notes the closed formulary applies to both certified network and non-network claims, and may not be amended by system participants."

   While the claim is part of a certified network, the treatment included in this dispute may not be delivered through a health care network and are subject to the fee guidelines found in 28 Texas Administrative Code §134.503 and the closed formula guidelines found in 28 Texas Administrative Code §134.540. Further, because prescription medications may not be delivered through a workers' compensation health care network, fee disputes involving prescription medications are subject to dispute resolution in accordance with 28 Texas Administrative Code §133.307.

2. The insurance carrier denied the disputed services in part with claim adjustment code "854 – Documentation does not support the initial use of the medication for this patient." Documentation requirements for medical billing are established by 28 Texas Administrative Code §133.210. This rule does not require documentation to be submitted with the medical bill for the disputed services. The insurance carrier's denial for this reason is not supported.

3. The insurance carrier denied the disputed services in part with claim adjustment code "CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." 28 Texas Administrative Code §133.210 states,

   (d) Any request by the insurance carrier for additional documentation to process a medical bill shall:
   (1) be in writing;
   (2) be specific to the bill or the bill's related episode of care;
   (3) describe with specificity the clinical and other information to be included in the response;
   (4) be relevant and necessary for the resolution of the bill;
   (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
   (6) indicate the specific reason for which the insurance carrier is requesting the information; and

(7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

Review of the submitted documentation does not indicate that the insurance carrier requested additional documentation in accordance with 28 Texas Administrative Code §133.210. Therefore, the insurance carrier's denial for this reason is not supported. The disputed services will be reviewed according to appropriate fee guidelines and rules.

4. The MAR in for the disputed services is established by the AWP formula pursuant to 28 Texas Administrative Code §134.503 (c), which states, in relevant part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider

   The requestor is seeking reimbursement for the generic drug cyclobenzaprine HCI 10 mg, NDC number 50111-0563-03, dispensed on March 20, 2015. The MAR is calculated as follows:

Date of Service	Prescription Drug	Calculation per §134.503 (c)(1)	§134.503 (c)(2)	Lesser of §134.503 (c)(1) & (2)	Carrier Paid	Balance Due
3/20/15	Cyclobenzaprine HCL 10 mg	(1.03050 x 60 x 1.25) + 4.00 = $81.29	$94.50	$81.29	$0.00	$81.29

5. The total MAR for the disputed charge is $81.29. The insurance carrier paid $0.00. Therefore, a reimbursement of $81.29 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $81.29.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $81.29 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 26, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.